



## Surgeon General's Report

U.S. Department of Health and Human Services, Office of the Surgeon General, SAMHSA

# Executive Summary

### Department of Health and Human Services, U.S. Public Health Service

America is home to a boundless array of cultures, races, and ethnicities. With this diversity comes incalculable energy and optimism. Diversity has enriched our Nation by bringing global ideas, perspectives, and productive contributions to all areas of contemporary life. The enduring contributions of minorities, like those of all Americans, rest on a foundation of mental health.

Mental health is fundamental to overall health and productivity. It is the basis for successful contributions to family, community, and society. Throughout the lifespan, mental health is the wellspring of thinking and communication skills, learning, resilience, and self-esteem. It is all too easy to dismiss the value of mental health until problems appear. Mental health problems and illnesses are *real and disabling* conditions that are experienced by one in five Americans. Left untreated, mental illnesses can result in disability and despair for families, schools, communities, and the workplace. This toll is more than any society can afford.

This report is a Supplement to the first ever Surgeon General's Report on Mental Health, *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services [DHHS], 1999). That report provided extensive documentation of the scientific advances illuminating our understanding of mental illness and its treatment. It found a range of effective treatments for most mental disorders. The efficacy of mental health treatment is so well documented that the Surgeon General made this single, explicit recommendation for all people: *Seek help if you have a mental health problem or think you have symptoms of a mental disorder.*

The recommendation to seek help is particularly vital, considering *the majority of people with diagnosable disorders, regardless of race or ethnicity, do not receive treatment.* The stigma surrounding mental

illness is a powerful barrier to reaching treatment. People with mental illness feel shame and fear of discrimination about a condition that is as real and disabling as any other serious health condition.

Overall, the earlier Surgeon General's report provided hope for people with mental disorders by laying out the evidence for what can be done to prevent and treat them. It strove to dispel the myths and stigma that surround mental illness. It underscored several overarching points about mental health and mental illness (see box). Above all, it furnished hope for recovery from mental illness.

But in the Preface to the earlier report, the Surgeon General pointed out that all Americans do not share equally in the hope for recovery from mental illness:

*Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender (DHHS,1999, p.vi).*

## **Mental Health: A Report of the Surgeon General**

### ***Themes of the Report***

- Mental health and mental illness require the broad focus of a public health approach.
- Mental disorders are disabling conditions.
- Mental health and mental illness are points on a continuum.
- Mind and body are inseparable.
- Stigma is a major obstacle preventing people from getting help.

### ***Messages from the Surgeon General***

- Mental health is fundamental to health.
- Mental illnesses are real health conditions.
- The efficacy of mental health treatments is well documented.
- A range of treatments exists for most mental disorders.

This Supplement was undertaken to probe more deeply into mental health disparities affecting racial and ethnic minorities. Drawing on scientific evidence from a wide-ranging body of empirical research, this Supplement has three purposes:

- To understand better the nature and extent of mental health disparities;
- To present the evidence on the need for mental health services and the provision of services to meet those needs; and
- To document promising directions toward the elimination of mental health disparities and the promotion of mental health.

This Supplement covers the four most recognized racial and ethnic minority groups in the United States. According to Federal classifications, African Americans (blacks), American Indians and Alaska Natives, Asian Americans and Pacific Islanders and white Americans (whites) are races. Hispanic American (Latino) is an ethnicity and may apply to a person of any race (U.S. Office of Management and Budget [OMB], 1978). For example, many people from the Dominican Republic identify their ethnicity as Hispanic or Latino and their race as black.

The Federal Government created these broad racial and ethnic categories in the 1970s for collecting census and other types of demographic information.<sup>1</sup> Within each of the broad categories, including white Americans, are many distinct ethnic subgroups. Asian Americans and Pacific Islanders, for example, include 43 ethnic groups speaking over 100 languages and dialects. For American Indians and Alaska Natives, the Bureau of Indian Affairs currently recognizes 561 tribes. African Americans are also becoming more diverse, especially with the influx of refugees and immigrants from many countries of Africa and the Caribbean. White Americans, too, are a profoundly diverse group, covering the span of immigration from the 1400's to the 21<sup>st</sup> century, and including innumerable cultural, ethnic, and social subgroups.

Each ethnic subgroup, by definition, has a common heritage, values, rituals, and traditions, but there is no such thing as a homogeneous racial or ethnic group (white or nonwhite). Though the data presented in this Supplement are often in the form of group averages, or sample means (standard scientific practice for illustrating group differences and health disparities), it should be well noted that each racial or ethnic group contains the full range of variation on almost every social, psychological, and biological dimension presented. One of the goals of the Surgeon General is that no one will come away from reading this Supplement without an appreciation for the intrinsic diversity within each of the recognized racial or ethnic groups and the implications of that diversity for mental health.

Clearly, the four racial and ethnic minority groups that are the focus of this supplement are by no means the only populations that encounter disparities in mental health services. However, assessing disparities for groups such as people who are gay, lesbian, bisexual, and transgender or people with co-occurring physical and mental illnesses is beyond the scope of this Supplement. Nevertheless, many of the conclusions of this Supplement could apply to these and other groups currently experiencing mental health disparities.

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<sup>1</sup> The Office of Management and Budget has recently separated Asian Americans from Native Hawaiians and other Pacific Islanders (OMB, 2000).

## **Main Findings**

### **Mental Illnesses are Real, Disabling Conditions Affecting All Populations, Regardless of Race or Ethnicity**

Major mental disorders like schizophrenia, bipolar disorder, depression, and panic disorder are found world-wide, across all racial and ethnic groups. They have been found across the globe, wherever researchers have surveyed. In the United States, the overall annual prevalence of mental disorders is about 21 percent of adults and children (DHHS, 1999). This Supplement finds that, based on the available evidence, the prevalence of mental disorders for racial and ethnic minorities in the United States is similar to that for whites.

This general finding about similarities in overall prevalence applies to minorities living in the community.<sup>2</sup> It does not apply to those individuals in vulnerable, high-need subgroups such as persons who are homeless, incarcerated, or institutionalized. People in these groups have higher rates of mental disorders (Koegel et al., 1988; Vernez et al., 1988; Breakey et al., 1989; Teplin, 1990). Further, the rates of mental disorders are not sufficiently studied in many smaller racial and ethnic groups — most notably American Indians, Alaska Natives, Asian Americans, and Pacific Islander groups

— to permit firm conclusions about overall prevalence within those populations.

This Supplement pays special attention to vulnerable, high-need populations in which minorities are over-represented. Although

individuals in these groups are known to have a high-need for mental health care, they often do not receive adequate services. This represents a critical public health concern, and this Supplement identifies as a course of action the need for earlier identification and care for these individuals within a coordinated and comprehensive service delivery system.

### **Striking Disparities in Mental Health Care Are Found for Racial and Ethnic Minorities**

This Supplement documents the existence of several disparities affecting mental health care of racial and ethnic minorities compared with whites:

- Minorities have less access to, and availability of, mental health services.
- Minorities are less likely to receive needed mental health services.
- Minorities in treatment often receive a poorer quality of mental health care.
- Minorities are underrepresented in mental health research.

The recognition of these disparities brings hope that they can be seriously addressed and remedied. This Supplement offers guidance on future courses of action to eliminate these disparities and to ensure equality in access, utilization, and outcomes of mental health care.

More is known about the disparities than the reasons behind them. A constellation of barriers deters minorities from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness (DHHS, 1999). But additional barriers deter racial and ethnic minorities; mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The ability for consumers<sup>3</sup> and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician. More broadly, mental health care disparities may also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. The cumulative weight and

interplay of all barriers to care, not any single one alone, is likely responsible for mental health disparities.

### **Disparities Impose a Greater Disability Burden on Minorities**

This Supplement finds that racial and ethnic minorities collectively experience a greater disability burden from mental illness than do whites. This higher level of burden stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community.

This finding draws on several lines of evidence. First, mental disorders are highly disabling for all the world's populations (Murray & Lopez, 1996; Druss et al., 2000). Second, minorities are less likely than whites to receive needed services and more likely to receive poor quality of care. By not receiving effective treatment, they have greater levels of disability in terms of lost workdays and limitations in daily activities. Further, minorities are overrepresented among the Nation's most vulnerable populations, which have higher rates of mental disorders and more barriers to care. Taken together, these disparate lines of evidence support the finding that minorities suffer a disproportionately high disability burden from unmet mental health needs.

The greater disability burden is of grave concern to public health, and it has very real consequences. Ethnic and racial minorities do not yet completely share in the hope afforded by remarkable scientific advances in understanding and treating mental disorders. Because of disparities in mental health services, a disproportionate number of minorities with mental illnesses do not fully benefit from, or contribute to, the opportunities and prosperity of our society. This preventable disability from mental illness exacts a high societal toll and affects all Americans. Most troubling of all, the burden for minorities is growing. They are becoming more populous, all the while experiencing continuing inequality of income and economic opportunity. Racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.

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<sup>2</sup> Most epidemiological studies using disorder-based definitions of mental illness are conducted in community household surveys. They

fail to include nonhousehold members, such as persons without homes or persons residing in institutions such as residential treatment centers, jails, shelters, and hospitals.

<sup>3</sup> Although a number of terms identify people who use or have used mental health services (e.g., mental health consumer, survivor, ex-patient, client), the terms “consumer” and “patient” will be used interchangeably throughout this Supplement.

## **Main Message: Culture Counts**

Culture and society play pivotal roles in mental health, mental illness, and mental health services. Understanding the wide-ranging roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of racial and ethnic minorities.

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings. The term “culture” is as applicable to whites as it is to racial and ethnic minorities. The dominant culture for much of United States history focused on the beliefs, norms, and values of European Americans. But today’s America is unmistakably multicultural. And because there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities.

With a seemingly endless range of cultural sub-groups and individual variations, culture is important because it bears upon what *all* people bring to the clinical setting. It can account for variations in how consumers communicate their symptoms and which ones they report. Some aspects of culture may also underlie *culture-bound syndromes* — sets of symptoms much more common in some societies than in others. More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness. All cultures also feature strengths, such as resilience and adaptive ways of coping, which may buffer some people from developing certain disorders. Consumers of mental health services naturally carry this cultural diversity directly into the treatment setting.

Culture is a concept not limited to patients. It also applies to the professionals who treat them. Every group of professionals embodies a “culture” in the sense that they too have a shared set of beliefs, norms, and values. This is as true for health professionals as it is for other professional groups such as engineers and teachers. Any professional group’s culture can be gleaned from the jargon they use, the orientation and emphasis in their textbooks, and from their mindset or way of looking at the world.

Health professionals in the United States and the institutions in which they train and practice are rooted in Western medicine which emphasizes the primacy of the human body in disease and the acquisition of knowledge through scientific and empirical methods. Through objective methods, Western medicine strives to uncover universal truths about disease: its causation, diagnosis, and treatment. Its achievements have become the cornerstone of medicine worldwide.

To say that physicians or mental health professionals have their own culture does not detract from the universal truths discovered by their fields. Rather, it means that most clinicians share a worldview about the inter-relationship between body, mind, and environment informed by knowledge acquired through the scientific method. It also means that clinicians view symptoms, diagnoses, and treatments in ways that sometimes diverge from their clients’ views, especially when the cultural backgrounds of the consumer and provider are dissimilar. This divergence of viewpoints can create barriers to effective care.

The culture of the clinician and the larger health care system govern the societal response to a patient with mental illness. They influence many aspects of the delivery of care, including diagnosis, treatments, and the organization and reimbursement of services. Clinicians and service systems, naturally immersed in their own cultures, have been ill-equipped to meet the needs of patients from different backgrounds and, in some cases, have displayed bias in the delivery of care.

The main message of this Supplement is that “culture counts.” The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated — *and they do count*. Cultural differences must be *accounted for* to ensure that



minorities, like all Americans, receive mental health care tailored to their needs.

## **Personal Health Recommendation: Seek Help**

The efficacy of treatment is well documented, according to the main finding of *Mental Health: A Report of the Surgeon General*. There is evidence, described in this Supplement, that racial and ethnic minorities benefit from mental health treatment. And it is abundantly clear that good treatment is preferable to no treatment at all. Untreated mental disorders can have dire consequences — distress, disability, and, in some cases, suicide. Therefore, this Supplement underscores the personal health recommendation of the earlier report: *Every person, regardless of race or ethnicity, should seek help if they have a mental health problem or symptoms of a mental disorder.*

Individuals are encouraged to seek help from any source in which they have confidence. If they do not improve with the help received from the first source, they are encouraged to keep trying. At present, members of minority groups may experience limited availability of, and access to, culturally sensitive treatments. With time, access to these services should improve as a result of awareness of this problem and the courses of action identified in this Supplement. In the meantime, anyone who needs help must hear a simple, yet resounding, message of hope: *Treatment works and recovery is possible.*

## **Organization of Supplement and Major Topics Covered**

The first chapter reviews the core messages of the original Surgeon General's Report on Mental Health. It also covers scope and terminology, the overall public health approach, and the science base for this Supplement. Chapter 2 lays the foundations for understanding the relationships among culture, society, mental health, mental illness, and mental health services. Chapters 3–6 provide information about each of the four major racial and ethnic minority groups, and Chapter 7 concludes with promising courses of action to reduce disparities and improve the mental health of racial and ethnic minorities.

Each chapter concerning a racial or ethnic minority group follows a common format. The chapter begins with the group's history in the United States, which is central to understanding contemporary ethnic identities, adaptive traditions, and health. Similarly, each chapter describes the group's demographic patterns, including their family

structure, income and education, and health status. These patterns reflect the group's history, and they are relevant for understanding that group's needs for mental health services. The chapter then reviews the available scientific evidence regarding the need for mental health services (as measured by prevalence), the availability, accessibility, and utilization of services, and the appropriateness and outcomes of mental health services.

## **Chapter Summaries & Conclusions**

### **Chapter 2: Culture Counts**

The cultures of racial and ethnic minorities influence many aspects of mental illness, including how patients from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service use, but they do play important roles.

- Cultural and social factors contribute to the causation of mental illness, yet that contribution varies by disorder. Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any of these major factors can be stronger or weaker depending on the specific disorder.
- Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty. Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation (known as socioeconomic status) are about two to three times more likely than those in the highest strata to have a mental disorder.
- Racism and discrimination are stressful events that adversely affect health and mental health. They place minorities at risk for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention.
- Mistrust of mental health services is an important reason deterring minorities from seeking treatment. Their concerns are reinforced by evidence, both direct and indirect, of clinician bias and stereotyping.

- The cultures of racial and ethnic minorities alter the types of mental health services they need. Clinical environments that do not respect, or are incompatible with, the cultures of the people they serve may deter minorities from using services and receiving appropriate care.

### Chapter 3: African Americans

The overwhelming majority of today's African American population traces its ancestry to the slave trade from Africa. The legacy of slavery, racism, and discrimination continues to influence the social and economic standing of this group. Almost one-quarter of African Americans are poor, and their per capita income is much lower than that of whites. They bear a disproportionate burden of health problems and higher mortality rates from disease. Nevertheless, African Americans are a diverse group, experiencing a range of challenges as well as successes in measures of education, income, and other indices of social well-being. Their steady improvement in social standing is significant and serves as testimony to the resilience and adaptive traditions of the African American community.

- **Need for Services:** For African Americans who live in the community, rates of mental illness appear to be similar to those for whites. In one study, this similarity was found **before**, and in another study, **after** controlling for differences in income, education, and marital status. But African Americans are overrepresented in vulnerable, high-need populations because of homelessness, incarceration, and, for children, placement in foster care. The rates of mental illness in high-need populations are much higher.
- **Availability of Services:** "Safety net" providers furnish a disproportionate share of mental health care to African Americans. The financial viability of such providers is threatened as a result of the national transformation in financing of health care over the past two decades. A jeopardized safety net reduces availability of care to African Americans. Further, there are very few African American mental health specialists for those who prefer specialists of their own race or ethnicity.
- **Access to Services:** African Americans have less access to mental health services than do whites. Less access results, in part, from lack of health insurance, especially for working poor who do not qualify for public coverage and who work in jobs that do not provide private health coverage. About 25 percent of African Americans are uninsured. Yet better insurance coverage

by itself is not sufficient to eliminate disparities in access because many African Americans with adequate private coverage still are less inclined to use services.

- **Utilization of Services:** African Americans with mental health needs are less likely than whites to receive treatment. If treated, they are likely to have sought help in primary care, as opposed to mental health specialty care. They frequently receive mental health care in emergency rooms and in psychiatric hospitals. They are overrepresented in these settings partly because they delay seeking treatment until their symptoms are more severe.
- **Appropriateness and Outcomes of Services:** For certain disorders (e.g., schizophrenia and mood disorders), errors in diagnosis are made more often for African Americans than for whites. The limited body of research suggests that, when receiving care for appropriate diagnoses, African Americans respond as favorably as do whites. Increasing evidence suggests that, in clinical settings, African Americans are less likely than whites to receive evidence-based care in accordance with professional treatment guidelines.

## Chapter 4: American Indians and Alaska Natives

American Indians and Alaska Natives (AI/ANs) flourished in North America for thousands of years before Europeans colonized the continent. As Europeans migrated westward through the 19th century, the conquest of Indian lands reduced the population to 5 percent of its original size. Movement to reservations and other Federal policies have had enduring social and economic effects, as AI/ANs are the most impoverished of today's minority groups. Over one quarter live in poverty, compared to 8 percent of whites. A heterogeneous grouping of more than 500 Federally recognized tribes, the AI/AN population experiences a range of health and mental health outcomes. While AI/ANs are, on average, five times more likely to die of alcohol-related causes than are whites, they are less likely to die from cancer and heart disease. The Indian Health Service, established in 1955, is the Federal agency with primary responsibility for delivering health and mental health care to AI/ANs. Traditional healing practices and spirituality figure prominently in the lives of AI/ANs — yet they complement, rather than compete with Western medicine.

- **Need for Services:** Research on AI/ANs is limited by the small size of this population and by its heterogeneity. Nevertheless,

existing studies suggest that youth and adults suffer a disproportionate burden of mental health problems and disorders. As one indication of distress, the suicide rate is 50 percent higher than the national rate. The groups within the AI/AN population with the greatest need for services are people who are homeless, incarcerated, or victims of trauma.

- **Availability of Services:** The availability of mental health services is severely limited by the rural, isolated location of many AI/AN communities. Clinics and hospitals of the Indian Health Service are located on reservations, yet the majority of American Indians no longer live on them. Moreover, there are fewer mental health providers, especially child and adolescent specialists, in rural communities than elsewhere.
- **Access to Services:** About 20 percent of AI/ANs do not have health insurance, compared to 14 percent of whites.
- **Utilization of Services:** An understanding of the nature and the extent to which AI/ANs use mental health services is limited by the lack of research. Traditional healing is used by a majority of AI/ANs.
- **Appropriateness and Outcomes of Services:** The appropriateness and outcomes of mental health care for AI/ANs have yet to be examined, but are critical for planning treatment and prevention programs.

## **Chapter 5: Asian Americans and Pacific Islanders**

Asian Americans and Pacific Islanders (AA/PIs) are highly diverse, consisting of at least 43 separate ethnic groups. The AA/PI population in the United States is increasing rapidly; in 2001, about 60 percent were born overseas. Most Pacific Islanders are not immigrants; their ancestors were original inhabitants of land taken over by the United States a century ago. While the per capita income of AA/PIs is almost as high as that for whites, there is great variability both between and within subgroups. For example, there are many successful Southeast Asian and Pacific Islander Americans; however, overall poverty rates for these two groups are much higher than the national average. AA/PIs collectively exhibit a wide range of strengths — family cohesion, educational achievements, and motivation for upward mobility — and risk factors for mental illness such as pre-immigration trauma from harsh social conditions.

Diversity within this population and other hurdles make research on AA/PIs difficult to carry out.

- ***Need for Services:*** Available research, while limited, suggests that the overall prevalence of mental health problems and disorders among AA/PIs does not significantly differ from prevalence rates for other Americans. Thus, contrary to popular stereotypes, AA/PIs are not, as a group, “mentally healthier” than other groups. Refugees from Southeast Asian countries are at risk for post-traumatic stress disorder as a result of the trauma and terror preceding their immigration.
- ***Availability of Services:*** Nearly half of AA/PIs have problems with availability of mental health services because of limited English proficiency and lack of providers who have appropriate language skills.
- ***Access to Services:*** About 21 percent of AA/PIs lack health insurance, but again there is much variability. The rate of public health insurance for AA/PIs with low income, who are likely to qualify for Medicaid, is well below that of whites from the same income bracket.
- ***Utilization of Services:*** AA/PIs have lower rates of utilization compared to whites. This underrepresentation in care is characteristic of most AAPI groups, regardless of gender, age, and geographic location. Among those who use services, the severity of their condition is high, suggesting that they delay using services until problems become very serious. Stigma and shame are major deterrents to their utilization of services.
- ***Appropriateness and Outcomes of Services:*** There is very limited evidence regarding treatment outcomes for AA/PIs. Because of differences in their rates of drug metabolism, some AA/PIs may require lower doses of certain drugs than those prescribed for whites. Ethnic matching of therapists with AAPI clients, especially those who are less acculturated, has increased their use of mental health services.

## Chapter 6: Hispanic Americans

The Spanish language and culture forge common bonds for many Hispanic Americans, regardless of whether they trace their ancestry to Africa, Asia, Europe or the Americas. Hispanic Americans are now the largest and fastest growing minority group in the United States.

Their per capita income is among the lowest of the minority groups covered by this Supplement. Yet there is great diversity among individuals and groups, depending on factors such as level of education, generation, and country of origin. For example, 27 percent of Mexican Americans live in poverty, compared to 14 percent of

Cuban Americans. Despite their lower average economic and social standing, which place many at risk for mental health problems and illness, Hispanic Americans display resilience and coping styles that promote mental health.

- ***Need for Services:*** Hispanic Americans have overall rates of mental illness similar to those for whites, yet there is wide variation. Rates are lowest for Hispanic immigrants born in Mexico or living in Puerto Rico, compared to Hispanic Americans born in the United States. Hispanic American youth are at significantly higher risk for poor mental health than white youth are by virtue of higher rates of depressive and anxiety symptoms, as well as higher rates of suicidal ideation and suicide attempts.
- ***Availability of Services:*** About 40 percent of Hispanic Americans in the 1990 census reported that they did not speak English very well. Very few providers identify themselves as Hispanic or Spanish-speaking. The result is that most Hispanic Americans have limited access to ethnically or linguistically similar providers.
- ***Access to Services:*** Of all ethnic groups in the United States, Hispanic Americans are the least likely to have health insurance (public or private). Their rate of uninsurance, at 37 percent, is twice that for whites.
- ***Utilization of Services:*** Hispanic Americans, both adults and children, are less likely than whites to receive needed mental health care. Those who seek care are more likely to go to primary health providers than to mental health specialists.
- ***Appropriateness and Outcomes of Services:*** The degree to which Hispanic Americans receive appropriate diagnoses is not known because of limited research. Research on outcomes, while similarly sparse, indicates that Hispanic Americans can benefit from mental health treatment. Increasing evidence suggests that Hispanic Americans are less likely in clinical settings to receive evidence-based care in accordance with professional treatment guidelines.

## **Chapter 7: A Vision for the Future**

This Supplement has identified striking disparities in knowledge, access, utilization, and quality of mental health care for racial and ethnic minorities. Reducing or eliminating these disparities requires a

steadfast commitment by all sectors of American society. Changing systems of mental health care must bring together the public and private sectors, health service providers, universities and researchers, foundations, mental health advocates, consumers, families, and communities. Overcoming mental health disparities and promoting mental health for all Americans underscores the Nation's commitment to public health and to equality. This chapter highlights promising courses of action for reducing barriers and promoting equal access to quality mental health services for all people who need them.

### ***1. Continue to expand the science base.***

Good science is an essential underpinning of the public health approach to mental health and mental illness. The science base regarding racial and ethnic minority mental health is limited but growing. Since 1994, the National Institutes of Health (NIH) has required inclusion of ethnic minorities in all NIH-funded research (NIH Guidelines, 1994, p. 14509). Several large epidemiological studies that include significant samples of racial and ethnic minorities have recently been initiated or completed. These surveys, when combined with smaller, ethnic-specific epidemiological surveys, may help resolve some of the uncertainties about the extent of mental illness among racial and ethnic groups.

These studies also will facilitate a better understanding of how factors such as acculturation, help-seeking behaviors, stigma, ethnic identity, racism, and spirituality provide protection from, or risk for, mental illness in racial and ethnic minority populations. The researchers have collaborated on a set of core questions that will enable them to compare how factors such as socioeconomic status, wealth, education, neighborhood context, social support, religiosity, and spirituality relate to mental illness. Similarly, it will be possible to assess how acculturation, ethnic identity, and perceived discrimination affect mental health outcomes for these groups. With these ground-breaking studies, the mental health field will gain crucial insight into how social and cultural factors operate across race and ethnicity to affect mental illness in diverse communities.

A major aspect of the vision for an adequate knowledge base includes research that confirms the efficacy of guideline- or other evidence-based treatments for racial and ethnic minorities. A special analysis performed for this Supplement reveals that the researchers who conducted the clinical trials used to generate treatment guidelines for several major mental disorders did not conduct specific analyses for



any minority group. While the lack of ethnic-specific analyses does not mean that current treatment guidelines are ineffective for racial or ethnic minorities, it does highlight a gap in knowledge. Nevertheless, these guidelines, extrapolated from largely majority populations, are clearly the best available treatments for major mental disorders affecting all Americans. As a matter of public health prudence, existing treatment guidelines should continue to be used as research proceeds to identify ways in which service delivery systems can better serve the needs of racial and ethnic minorities.

The science base of the future will also determine the efficacy of ethnic- or culture-specific interventions for minority populations and their effectiveness in clinical practice settings. In the area of psychopharmacology, research is needed to determine the extent to which the variability in peoples' response to medications is accounted for by factors related to race, ethnicity, age, gender, family history, and/or lifestyle.

This Supplement documents the fact that minorities tend to receive less accurate diagnoses than whites. While further study is needed on how to address issues such as clinician bias and diagnostic accuracy, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, now under development, will extend and elaborate the "Glossary of Culture-Bound Syndromes," the "Outline for Cultural Formulation," and other concepts introduced in DSM-IV regarding the role and importance of culture and ethnicity in the diagnostic process.

In terms of the promotion of mental health and the prevention of mental and behavioral disorders, important opportunities exist for researchers to study cultural differences in stress, coping, and resilience as part of the complex of factors that influence mental health. Such work will lay the groundwork for developing new prevention and treatment strategies — building upon community strengths to foster mental health and ameliorate negative health outcomes.

## **2. Improve access to treatment.**

Simply put, the Nation's health systems must work to bring mental health services to where the people are.

Many racial and ethnic minorities live in areas where general health care and specialty mental health care are in short supply. One major course of action is to *improve geographic availability of mental health*

*services*. Innovative strategies for training providers, delivering services, creating incentives for providers to work in underserved areas, and strengthening the public health safety net promise to provide greater geographic access to mental health services for those in need.

Another step towards better access to care is to *integrate mental health care and primary care*. Primary care is where many minority individuals prefer to receive mental health care and where most people who need treatment are first recognized and diagnosed. A variety of research and demonstration programs have been or will be created to strengthen the capacity of these providers to meet the demand for mental health services and to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve.

Another major step in improving access to mental health services is to *improve language access*. Improving communication between clinicians and patients is essential to mental health care. Service providers receiving Federal financial assistance have an obligation under the 1964 Civil Rights Act to ensure that people with limited English proficiency have meaningful and equal access to services (DHHS, 2000).

Finally, a major way to improve access to mental health services is to *coordinate care to vulnerable, high-need groups*. People from all backgrounds may experience disparities in prevalence of illness, access to services, and quality of services if they are in under-served or vulnerable populations such as people who are incarcerated or homeless and children living in out of home placements. As noted earlier, racial and ethnic minorities are overrepresented in these groups. To prevent individuals from entering these vulnerable groups, early intervention is an important component to systems of care, though research is needed to determine which interventions work best at prevention. For individuals already in underserved or high-need groups, mental health services, delivered in a comprehensive and coordinated manner, are essential. It is not enough to deliver effective mental health treatments: Mental health and substance abuse treatments must be incorporated into effective service delivery systems, which include supported housing, supported employment, and other social services (DHHS, 1999).

### **3. Reduce barriers to mental health care.**

The foremost barriers that deter racial and ethnic minorities from reaching treatment are the cost of services, the fragmented organization of these services, and societal stigma toward mental illness. These obstacles are intimidating for all Americans, yet they may be even more formidable for racial and ethnic minorities. The Nation must strive to dismantle these barriers to care.

*Mental Health: A Report of the Surgeon General* (DHHS, 1999) spotlighted the importance of overcoming stigma, facilitating entry into treatment, and reducing financial barriers to treatment (DHHS, 1999). This Supplement brings urgency to these goals. It aims to make services more accessible and appropriate to racial and ethnic minorities, it encourages mental health coverage for the millions of Americans who are uninsured, and it maintains that parity, or equivalence, between mental health coverage and other health coverage is an affordable and effective strategy for reducing racial and ethnic disparities.

#### ***4. Improve quality of mental health services.***

Above all, improving the quality of mental health care is a vital goal for the Nation. Persons with mental illness who receive quality care are more likely to stay in treatment and to have better outcomes. This result is critical, as many treatments require at least four to six weeks to show a clear benefit to the patient. Through relief of distress and disability, consumers can begin to recover from mental illness. They can become more productive and make more fulfilling contributions to family and community.

Quality care conforms to professional guidelines that carry the highest standards of scientific rigor. *To improve the quality of care for minorities, this Supplement encourages providers to deliver effective treatments based on evidence-based professional guidelines.* Treatments with the strongest evidence of efficacy have been incorporated into treatment guidelines issued by organizations of mental health professionals and by government agencies.

A major priority for the Nation is to transform mental health services by tailoring them to meet the needs of all Americans, including racial and ethnic minorities. To be most effective, *treatments always need to be individualized in the clinical setting according to each patient's age, gender, race, ethnicity, and culture* (DHHS, 1999). No simple blueprint exists for how to accomplish this transformation, but there are many promising courses of action for the Nation to pursue.

At the same time, research is needed on several fronts, such as how to adapt evidence-based treatments to maximize their appeal and effectiveness for racial and ethnic minorities. While “ethnic-specific” and “culturally competent” service models take into account the cultures of racial and ethnic groups, including their languages, histories, traditions, beliefs, and values, these approaches to service delivery have thus far been promoted on the basis of humanistic values rather than rigorous empirical evidence. Further study may reveal how these models build an important, yet intangible, aspect of treatment: trust and rapport between patients and service providers.

### ***5. Support capacity development.***

This Supplement encourages all mental health professionals to develop their skills in tailoring treatment to age, gender, race, ethnicity, and culture. In addition, because minorities are dramatically underrepresented among mental health providers, researchers, administrators, policy makers, and consumer and family organizations, racial and ethnic minorities are encouraged to enter the mental health field. Training programs and funding sources also need to work toward equitable racial and ethnic minority representation in all these groups.

Another way to support capacity development and maximize systems of care is to promote leadership from within the community in which a mental health system is located. Issues of race, culture, and ethnicity may be addressed while engaging consumers, families, and communities in the design, planning, and implementation of their own mental health service systems. To reduce disparities in knowledge, and the availability, utilization, and quality of mental health services for racial and ethnic minority consumers, mental health educational, research, and service programs must develop a climate that conveys an appreciation of diverse cultures and an understanding of the impact of these cultures on mental health and mental illness. Doing so will help systems better meet the needs of all consumers and families, including racial and ethnic minorities.

### ***6. Promote mental health.***

Mental health promotion and mental illness prevention can improve the health of a community and the Nation. Because mental health is adversely affected by chronic social conditions such as poverty, community violence, racism, and discrimination, the reduction of these adverse conditions is quite likely to be vital to improving the mental health of racial and ethnic minorities.

Efforts to prevent mental illness and promote mental health should build on intrinsic community strengths such as spirituality, positive ethnic identity, traditional values, educational attainment, and local leadership. Programs founded on individual, family, and community strengths have the potential to both ameliorate risk and foster resilience.

Families are the primary source of care and support for the majority of adults and children with mental problems or disorders. Efforts to promote mental health for racial and ethnic minorities must include strategies to strengthen families to function at their fullest potential and to mitigate the stressful effects of caring for a relative with a mental illness or a serious emotional disturbance.

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